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ABSTRACT

The monograph presents information designed to help speech/language pathologists in South Carolina improve the quality of services for children with communication disorders while still complying with mandates of P.L. 94-142, the Education for All Handicapped Children Act. A discussion is presented regarding a continuum of appropriate services, including consultation with parents, teachers, or pupils; indirect pupil involvement; weekly small group therapy sessions; and daily individual sessions. Guidelines are offered regarding determination of eligibility for services based on the South Carolina Severity Rating Scales, which identify priority needs in articulation, fluency, voice, and language. Worksheets and information are provided for each of the four areas, with names of suggested evaluation measures appended. The manual concludes with a listing of type of services and service eligibility requirements for educable mentally handicapped, trainable mentally handicapped, and profoundly mentally handicapped students. (CL)

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GUIDELINES FOR CASE SELECTION AND PRIORITIZING PUPILS FOR PARTICIPATION IN SPEECH/LANGUAGE PROGRAMS/SERVICES

Dr. Charles C. Williams, Superintendent
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GUIDELINES FOR CASE SELECTION AND PRIORITIZING PUPILS FOR PARTICIPATION IN SPEECH/LANGUAGE PROGRAMS/SERVICES

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INTRODUCTION

Background Information

The passage of Public Law 94-142, The Education of all Handicapped Children Act of 1975, mandated that handicapped children be provided a Free Appropriate Public Education (FAPE). In order to determine the degree of compliance with the Act, the South Carolina Department of Education, like other state education agencies throughout the nation, began to review existing policies and regulations. By the authority of this Act, states not only were required to meet the "spirit" of the law, but also were required to meet the "letter" of the law. As we in the Office of Programs for the Handicapped (OPH) began to examine potential problem areas, a main concern became the provision of appropriate services to speech/language handicapped children. Services for speech/language handicapped children were provided by all local education agencies (LEAs), but speech/language clinicians were reporting that the caseload was prohibitive to the provision of quality services.

From the regulations for the implementation of Public Law 94-142, evolved voluminous amounts of paperwork necessary in the development of Individualized Education Programs, and in fulfilling the consent and other rights of the parents and the rights of handicapped children served in LEAs. Additionally, the thrust for parental involvement went far beyond merely contacting parents through written correspondence but necessitated telephone calls, parent conferences and in some instances home visits. Speech/language clinicians were also responsible for conducting speech/language screening and, in some cases, hearing screening. They were responsible for providing indepth diagnostic evaluations for all pupils who failed the speech/language screening and were responsible for providing appropriate therapeutic services.

Several strategies were defined by the OPH to improve the quality of services for speech/language handicapped children. The first to be undertaken was a revision in the caseload requirements. Acting on the recommendation to reduce the caseload requirements, the State Board of Education adopted a regulation which eliminated the minimum caseload requirement and established a maximum continuous caseload requirement that prohibits a clinician from serving more than sixty (60) pupils at any given time.

Developing Criteria for Case Selection and Prioritizing Pupils for Participation in Speech/Language Programs/Services

The second strategy was to develop guidelines for case selection and service delivery. It should be noted that the State of Iowa had previously undertaken the task of developing and implementing the use of severity rating scales. Many positive results emerged from the use of these scales in that they:[1]

1. Provide for the establishment of a clinician's caseload based upon hierarchical priorities relating to the individual needs of pupils for therapeutic services.
2. Provide consistency in determining the severity of pupils' speech/language problems and treatment strategies.
3. Provide a rationale for scheduling pupils for the frequency and intensity of services which are required.
4. Serve as an effective pre-post-test for evaluating progress.
5. Assist in determining the schools, grades or classes within an LEA which warrant more of the clinician's time.

During the 1980-81 school year a task force consisting of speech/language clinicians representing LEAs of varying size and geographic distribution throughout the state was established to provide input in the development of guidelines for case selection and prioritizing pupils for participation in speech/language programs and services in South Carolina. The work of the task force culminated in the following:

1. The development of severity rating scales for the areas of articulation, language, voice and fluency.
2. Recommended service delivery models compatible with pupils' severity classification.
3. Identifying and rating the impact of dialectal differences on communication skills when they occur unilaterally or coexist with speech/language problems.

4. Developing guidelines for determining the need for services and recommended service delivery models for Educable Mentally Handicapped (EMH), Trainable Mentally Handicapped (TMH), and Profoundly Mentally Handicapped (PMH) children.

The initial draft of the guidelines was disseminated to all LEAs for comment. The guidelines were, then, revised during the 1981-82 school year, and utilized in 95% of the LEAs in South Carolina. Approximately one (1) year later, a questionnaire was diffused to approximately 30% of the LEAs utilizing the guidelines. The vast majority of the respondents reported favorable results from utilizing the guidelines; all of the comments were reviewed and sections of the guidelines were revised.

The Procedures for Survey, Screening, Evaluation, Placement and Dismissal of Pupils Into/Out-of Programs for the Handicapped defines a speech/language handicap as being those "disorders which tend to interfere with or limit, to varying degrees, the individual's ability to formulate, express, receive or interpret oral language. Speech and language handicaps may be manifested in degrees of mild, moderate or severe and be exhibited as disorders of articulation, voice, rhythm, language, delayed speech and language, and speech/language disorders associated with cleft palate, cerebral palsy conditions, or hearing loss. Speech and language behavior, associated with dialectal differences, may indicate a need for the availability of appropriate services, optional for pupil participation." It should be noted that the severity rating classifications are consistent with that general definition in terms of utilizing mild, moderate and severe to describe severity. The definition of each communication problem which prefaces the severity rating scale for each area is also consistent with State Board of Education regulations.

The members of the task force are to be commended for the diligence, efficiency and enthusiasm with which they approached this difficult task. They have made a noteworthy contribution toward accomplishing the foremost goal of the Office of Programs for the Handicapped which is to provide quality programs and services for all handicapped pupils. Although these guidelines are not mandatory, we are hopeful that they will be of assistance to those LEAs which choose to implement them.

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THE CONTINUUM OF SERVICES FOR PUPILS WITH COMMUNICATION DISABILITIES

It is evident that all communication disorders occur somewhere along a continuum from adequate at one extreme to inadequate at the other. Pupils may exhibit minor developmental delays, mild or moderate deviations, or severe disorders which demand intensive clinical/educational intervention. The determination of the presence of a speech "problem" in and of itself is not sufficient justification for direct clinical/educational intervention by a speech and language clinician.[1]

Establishing pupil eligibility for various service delivery models should include consideration of factors in two broad areas: the severity of the pupil's communication problem(s) in terms of any present and future personal, social, and educational handicaps and the prognosis for remediating or diminishing the severity of the speech/language problem(s) through the provision of appropriate services.[1]

State Board of Education regulations provide that the speech/language clinician is to be responsible for determining the type of program, the extent of services to be provided and the length and frequency of direct/indirect contacts with the pupil. The speech/language clinician, upon the advice and consent of the superintendent or his designee, also determines the appropriate method of scheduling (itinerant, intensive cycling). The continuum of appropriate services includes, but is not limited to, the following:[2]

a. Consultation with parents, teachers or pupils.

b. Indirect pupil involvement through assistance to teachers and/or parents.

c. Speech Improvement/Language Development classes (designed to serve large groups).

d. Weekly therapy sessions in small groups (should include 3 or more sessions per week and not exceed four (4) pupils).

e. Weekly individual therapy sessions (in most cases 2, 3 or more sessions per week).

f. Daily group therapy sessions (should not exceed four (4) pupils).

g. Daily individual therapy sessions.

DESCRIPTIONS OF SEVERITY RATING CLASSIFICATIONS

DEVELOPMENTAL COMMUNICATION DELAYS

This classification relates to pupils exhibiting mild maturational delays in the acquisition or use of articulation or language, or slight or infrequent deviations in voice or fluency.[1]

COMMUNICATION DEVIATIONS

Pupils classified as having communication deviations generally display mild to moderate deficits in voice, fluency, language or articulation which may moderately impair academic, social, personal or emotional adjustment.[1]

COMMUNICATION DISORDERS

Pupils in this classification exhibit severe deficits in the areas of voice, fluency, language or articulation to the degree that normal adjustment is frequently affected. These pupils may be handicapped academically, socially, personally and/or emotionally by the presence of a communication disorder.[1]

DIALECTAL DIFFERENCE

Pupils classified as having dialectal differences exhibit linguistic features which are common to a particular cultural group including native speakers of a foreign language, speakers from a particular geographic region, and speakers of Black dialect. The pupil's use of word formation rules must always be evaluated against the dialectal background in order to determine which deviations must be attributed to dialectal differences and which to deficits in the acquisition of the standard rules.[1]

SOUTH CAROLINA SEVERITY RATING SCALES (SCSRS)

The *South Carolina Severity Rating Scales* (SCSRS) were developed to facilitate consistency and objectivity in determining a pupil's eligibility for services and the type of services required following the completion of an evaluation as prescribed by State Board of Education regulations. The SCSRS address speech and language problems in the areas of articulation, fluency, voice and language. Code letters may be utilized to represent these areas:

A = articulation
F = fluency
V = voice
L = language

The SCSRS are five (5) point scales from which a severity rating and a severity classification, as indicated below, can be derived:

Severity Rating	*Severity Classification*
0	Normal
1	Developmental
2	Deviation (mild)
3	Deviation (moderate)
4 or 4+	Disorder (severe)

Guidelines for determining the "severity" of a child's performance in the areas of A, F, V or L are outlined in Part I of the worksheets for each of these respective areas. Pertinent factors which must be considered by a clinician prior to determining the "severity rating" are outlined in Part II of the worksheets for each respective area. These factors may support the severity obtained in Part I or provide a rationale for exercising clinical judgment to *raise* or *lower* the severity rating by one level. The clinician should be able to provide specific documentation for raising or lowering the severity rating.

Example 1.

Completion of Part I of the Articulation Worksheet (p. 10) indicates that a child exhibits a severity rating of three (3) which is equivalent to the severity classification, deviation (moderate). Completion of Part II of the Articulation Worksheet (p. 11) indicates that the majority of pertinent factors are representative of the severity rating of two (2) which is equivalent to the deviation (mild) classification. A clinician will judge the impact of the various factors in determining whether the severity rating/classification will be two (2), deviation (mild) or three (3), deviation (moderate).

When more than one of the areas, A, F, V or L, are involved, a child's communication performance can be no *lower* than the *highest severity rating* for a given area and no *higher* than the *combined severity ratings* of the areas represented. If the combined ratings numerically would exceed four (4), disorder (severe), the severity rating would be presented as 4+.

Example 2.

If a child receives a severity rating of two (2) in articulation and a severity rating of one (1) in language, the final severity rating can be no lower than two (2) and no higher than three (3).

Example 3.

If a child receives a severity rating of two (2) in language and a severity rating of two (2) in fluency, the final severity rating can be no lower than two (2) and no higher than four (4).

A form entitled "Eligibility for Speech/Language Services" has been developed to be utilized conjointly with the severity rating scales developed for each area (Reference Appendix A). Please note, however, that the utilization of this form is optional.

RECOMMENDED TREATMENT STRATEGIES

Rating	Classification	Treatment Strategies
0	Normal	Treatment is not indicated.
1	Developmental	Direct therapy is not indicated. The speech/language clinician should serve as a consultant to the parent and/or the classroom teacher. Demonstration lessons may be provided by the speech/language clinician to assist the teacher in providing speech improvement/language development instruction in the classroom.
2	Deviation (mild)	Direct therapy is not a high priority; however, therapy may be considered in particular situations. In most instances, the speech/language clinician should serve as a consultant to the parent and/or the classroom teacher. Speech improvement/language development activities provided by the clinician may also be implemented. A follow-up re-check is recommended.
3	Deviation (moderate)	Direct therapy is recommended.
4	Disorder (severe)	Direct therapy is recommended.
D	Dialectal Differences	Speech improvement instruction provided conjointly with teachers in the classroom setting is recommended. The approach most commonly utilized is the teaching of standard English as an alternative language or as a second language.

ARTICULATION

I. Definition

Substitution of one phoneme for another, distortion of phonemes, and omission or addition of phonemes.[2]

II. Assessment Considerations

Clinicians must consider for every student evaluated, regardless of age, various factors which may have an affect upon the speech severity and prognosis for improvement. In particular, five (5) and six (6) year old students may exhibit developmental errors which, due to the type and frequency of errors, degree of stimulability and the intelligibility, may need to be considered for therapy.

III. Criteria for Case Selection

Criteria for case selection for Educable Mentally Handicapped (EMH), Trainable Mentally Handicapped (TMH) and Profoundly Mentally Handicapped (PMH) are addressed in separate sections (reference pages 23 and 24).

Rating	Classification	Characteristics
0	Normal Articulation	No articulation errors.
1	Developmental	Correct articulation of *all* phonemes (including vowels) that are expected to have developed within one (1) year of child's chronological/mental age (e.g., a seven (7) year old child should correctly articulate *all* sounds at the six (6) year old level and below). Misarticulations occur *only* for phonemes which are not yet necessarily age-appropriate and are usually inconsistent. (*Articulation Error Score* (page 10) does not apply to this category.)
2	Deviation (mild)	Misarticulations include, but are not necessarily limited to, a phoneme or phonemes which already should have been acquired within one (1) year of the child's chronological/mental age. Misarticulations are often *inconsistent*. Speech is intelligible although noticeably in error and/or the child obtains an *Articulation Error Score* of *1* to *3* (page 10).
3	Deviation (moderate)	Misarticulations are frequently consistent. Speech is generally intelligible but may require careful listening and/or the child obtains an *Articulation Error Score* of *4* to *7* (page 10).
4	Disorder (severe)	Misarticulations are usually consistent. Speech is difficult to understand or is unintelligible and/or the child obtains an *Articulation Error Score* of *8* or *above* (page 10).
D	Dialectal Differences	Consistent misarticulation of phonemes, whether substituted, omitted or distorted, which is common to a particular cultural, racial, or ethnic group including native speakers of a foreign language, speakers from a particular geographic region, and speakers of Black dialect. Speakers will generally exhibit three (3) or more of the phonological features characteristic of their particular dialect. A listing of a number of the phonological features of one of the more common dialects, Black dialect, can be found in Appendix B, page 26.

The presence of a dialect alone (0D) does not usually result in an interference of communication within that speech community. However, since a dialect can co-exist with articulation problems students may be ranked as follows:

0D Dialect speaker with no articulation problem.
1D Dialect speaker with a developmental articulation problem.
2D Dialect speaker with a mild articulation deviation.
3D Dialect speaker with a moderate articulation deviation.
4D Dialect speaker with a severe articulation disorder.

REFERENCE APPENDIX F FOR LISTING OF TESTS FOR EVALUATING ARTICULATION

ARTICULATION WORKSHEET

I. Instructions for determining *Articulation Error Score.*

A. Compute *Articulation Error Score*

1. Administer an articulation test to the student. It is also desirable to obtain a conversational speech sample in order to help assess articulatory proficiency.
2. Select error phonemes which are age appropriate for the student (Reference Chart below).

AGE SPEECH SOUNDS DEVELOP (NORMS)[3]

Chronological Age in Years	Sound
2½	all vowels except ɝ
3	/p, b, m/
3½	all rising diphthongs
4	/n, ng, w, h/
4½	/t, d, k, g/
5	/f, v, y/
5½	/θ, ð, l/
6	/r, ɝ, s, z, sh, ʒ, ch, j/ and all centering diphthongs
7	all consonant blends

(Regardless of the number of blend errors in a given blend family, compute the misarticulations as one phoneme in error.)

3. Test each error phoneme for stimulability in isolation. The phoneme is stimulable if the student can correctly produce three (3) or more of ten (10) responses.
4. Determine weighted values for each error phoneme, regardless of the position in which the error occurs in the word(s), according to the following scale (rate *only* sounds which are developmentally appropriate for the student):

	Weighted Values	
	Non-Stimulable	Stimulable
Each substituted or distorted phoneme	3	1
Each omitted phoneme	3	2

5. Calculate weightings:
   a. Number of stimulable substituted/distorted phonemes: _____ x 1.....+_____
   b. Number of non-stimulable substituted/distorted phonemes: _____ x 3.+_____
   c. Number of stimulable omitted phonemes: _____ x 2.....+_____
   d. Number of non-stimulable omitted phonemes: _____ x 3.....+_____
6. Add all weighted values to obtain the *Articulation Error Score*.....=_____

B. Determine the severity based on *Articulation Error Score* and indicate with a check (✓) below.

_____ Error Score Not Appropriate — Developmental
_____ 1 to 3 — Deviation (Mild)
_____ 4 to 7 — Deviation (Moderate)
_____ 8 or above — Disorder (Severe)

II. Other factors to be considered check (✓) as appropriate. These factors may be utilized to *raise* or *lower* the severity by one level, if necessary.

FACTORS	SELDOM (developmental)	OCCASIONALLY (deviation-mild)	FREQUENTLY (deviation-moderate)	ALMOST ALWAYS (disorder-severe)
A. Speech is difficult to understand or unintelligible				
B. Student is aware of or concerned about articulation errors				
C. Others (parents, teachers, peers) are aware of or concerned about articulation errors				
D. Multiple errors occur involving two- or three-element consonant blends and/or in blend clusters				
E. Multiple phoneme errors occur in more than one position in connected speech				
F. Phonemic errors are stabilized (not likely to self-correct)				
G. Other (specify)				

III. Articulation Severity Rating (Check (✓) below):

_____ 0 — Normal Articulation	_____ D — Dialect
_____ 1 — Developmental	_____ D — Dialect
_____ 2 — Deviation (Mild)	_____ D — Dialect
_____ 3 — Deviation (Moderate)	_____ D — Dialect
_____ 4 — Disorder (Severe)	_____ D — Dialect

FLUENCY

I. Definition

Abnormal disruptions in the normal flow of verbal expression that are markedly noticeable and are not readily controllable by the pupil.[2]

(These disruptions may be described in terms of repetitions, prolongations, blocks, hesitations, interjections, broken words, revisions, incomplete phrases and secondary characteristics that suggest stress or struggle.)[4]

II. Assessment Considerations

When evaluating pupils with fluency problems, consideration must be given to age and environmental situations. Information obtained from psychological assessment and case history may be beneficial when determining eligibility for therapy.

III. Criteria for Case Selection

Rating	Classification	Characteristics
0	Normal Fluency	No fluency problems.
1	Developmental	Observable nonfluent speech behavior present. Child is not concerned about or aware of the nonfluent speech. Normal speech periods reported or observable and predominant. Obtains a *Dysfluency Score* of *1* to *4* or approximately *1%* to *4%* (page 13).
2	Deviation (mild)	Observable nonfluent speech behavior present and observable on a regular basis. Child is becoming aware of the problem, and parents, teachers, or peers are aware and concerned. Obtains a *Dysfluency Score* of *5* to *8* or approximately *5%* to *11%* (page 13).
3	Deviation (moderate)	Stuttering behavior is noted on a regular basis. Child is aware of a problem in communicating. Struggle, avoidance, or other coping behaviors are observed at times. Obtains a *Dysfluency Score* of *9* to *11* or approximately *12%* to *22%* (page 13).
4	Disorder (severe)	Communication is an effort. Avoidance and frustrations are obvious. Struggle behavior is predominant. Obtains a *Dysfluency Score* of *12* or *above* or *23%* or more (page 13).

REFERENCE APPENDIX F FOR LISTING OF TESTS FOR EVALUATING FLUENCY

FLUENCY WORKSHEET

I. Instructions for determining *Dysfluency Score*.

A. Use *either* Procedure 1 or 2.

1. *Dysfluency Score* using stuttered words per minute.[4]

a. Obtain three 3-minute speech samples during reading (if appropriate), monologue and conversation.

b. Calculate stuttered words per minute (sw/m) during the speech samples by dividing the total number of stuttered words by the total number of minutes of talking time. Enter sw/m here..... _____

c. Determine the *most severe* type of dysfluency observed during the speech sample. Determine the weighted value of this type of dysfluency from the chart below. Enter the highest weighted value here.....x _____

d. Multiply this weighted value by the number of stuttered words per minute to obtain the Dysfluency Score..... = _____

Type of Dysfluency	*Weighted Value*
Whole word repetitions	1
Hesitations	1
Interjections	1
Broken words	1
Revisions	1
Incomplete phrases	1
Part-word repetitions	2
Prolongations	3
Struggle	4
Blocks	4
Severe struggles (lasting 3 or more seconds)	5
Severe blocks (lasting 3 or more seconds)	5

2. *Dysfluency Score* using percentage of dysfluency.[5]

a. Obtain three 3-minute speech samples during reading (if appropriate), monologue and conversation.

b. Determine the number of dysfluent words. Enter here..... _____

c. Determine the total number of words obtained during the speech samples. Enter here..... ÷ _____

d. Divide the number of dysfluent words by the total number of words to obtain the *Dysfluency Score*..... = _____%

B. Determine severity based on *Dysfluency Score* and indicate with a check (✓) below.

_____ developmental.....1 to 4 *or* 1% to 4%
_____ deviation (mild).....5 to 8 *or* 5% to 11%
_____ deviation (moderate).....9 to 11 *or* 12% to 22%
_____ disorder (severe).....12 or above *or* 23% or more

II. Other factors to be considered (check (✓) as appropriate). These factors may be used to *raise* or *lower* severity by one level if necessary.

FACTORS	SELDOM (developmental)	OCCASIONALLY (deviation-mild)	FREQUENTLY (deviation-moderate)	ALMOST ALWAYS (disorder-severe)
A. Dysfluent periods occur				
B. Student is aware of or concerned about dysfluencies				
C. Others (parents, teachers, peers) are aware of or concerned about dysfluencies				
D. Dysfluencies affect communication				
E. Struggle is observed				
F. Avoidance and/or secondary characteristics are observed				
G. Other (specify)				

III. Fluency Severity Rating (Check (✓) below):

_____ 0 — Normal Fluency
_____ 1 — Developmental
_____ 2 — Deviation (Mild)
_____ 3 — Deviation (Moderate)
_____ 4 — Disorder (Severe)

_____ D — Dialect
_____ D — Dialect
_____ D — Dialect
_____ D — Dialect
_____ D — Dialect

VOICE

I. Definition

Abnormality in pitch, loudness, and quality, or a combination thereof, resulting from pathological conditions (deviations in size, shape, tonicity, surface conditions, and muscular control of the phonating and resonating mechanisms), psychogenic factors or inappropriate use of the vocal mechanism. Characteristics of voice production related only to cultural differences are not appropriately classified as voice disorders.[2]

II. Assessment Considerations

When evaluating pupils with voice problems, consideration must be given to age, sex and cultural differences of the pupil. The clinician should utilize current medical information if available.

III. Criteria for Case Selection

Rating	Classification	Characteristics
0	Normal	No voice problems.
1	Developmental	Vocal production is inconsistent or slightly deviant; is not distracting to the listener and is appropriate for chronological/mental age, sex, and ability.
2	Deviation (mild)	Vocal production exhibits inconsistent deviations; is not distracting to the majority of listeners and is inappropriate for chronological/mental age, sex, and ability. Obtains *Vocal Characteristics Score* of *2* to *4* (page 16).
3	Deviation (moderate)	Vocal production exhibits consistent deviations; is distracting to the majority of listeners and is inappropriate for chronological/mental age, sex, and ability. Obtains *Vocal Characteristics Score* of *5* to *7* (page 16). A medical referral is indicated.
4	Disorder (severe)	Vocal production exhibits a significant deviation; it is distracting to the majority of listeners and is inappropriate for chronological/mental age, sex, and ability. Obtains *Vocal Characteristics Score* of *8* and *above* (page 16). A medical referral is indicated.

VOICE WORKSHEET

I. Instructions for determining *Vocal Characteristics Score.*[8]

A. Check (✓) the applicable vocal characteristics below.

Check	Vocal Characteristics	Weight
_____	pitch too high or too low	1
_____	too loud or too soft	1
_____	breathy	1
_____	hoarse	1
_____	nasality (hyper- or hypo-)	1
_____	persisting more than one month	1
_____	interferes with intelligibility	2
_____	falsetto	3
_____	unable to sustain phonation 6 seconds	3
_____	diplophonic	3
_____	intermittent loss of phonation	3
_____	laryngeal pathology present	3
_____	contributing/related factors (i.e., cleft palate, cerebral palsy, hearing loss, etc.)	3

B. Determine the *Vocal Characteristics Score* by adding the weighted values checked above.

Enter the total here _____

C. Determine the severity based on the above *Vocal Characteristics Score.*

_____ 1	— developmental
_____ 2 to 4	— deviation (mild)
_____ 5 to 7	— deviation (moderate)
_____ 8 or above	— disorder (severe)

II. **Other factors to be considered. Check (✓) as appropriate. These factors may be used to *raise* or *lower* the above severity one level, if appropriate.**

FACTORS	SELDOM (developmental)	OCCASIONALLY (deviation-mild)	FREQUENTLY (deviation-moderate)	ALMOST ALWAYS (disorder-severe)
A. Student is aware of or concerned about inappropriate voice				
B. Others (parents, teachers, peers, etc.) are aware of or concerned about student's voice				
C. Vocal behavior interferes with intelligibility				
D. Voice is *not* appropriate for chronological, mental age, sex, and ability				
E. Inappropriate vocal behavior results in avoidance of speaking situations				
F. Voice is distracting to listeners				
G. Other (specify)				

III. Voice Severity Rating (check (✓) below):

_____ 0 — Normal Voice
_____ 1 — Developmental
_____ 2 — Deviation (mild)
_____ 3 — Deviation (moderate)
_____ 4 — Disorder (severe)

_____ D — Dialect
_____ D — Dialect
_____ D — Dialect
_____ D — Dialect
_____ D — Dialect

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LANGUAGE

I. Definitions

a. Categories of Language Handicapping Conditions

1. Language Disorder — an impairment in the ability to decode or encode spoken or written language, which may involve phonology, morphology, syntax, semantics, or a combination thereof.[2]

2. *Delayed Speech and Language* — impaired communication skills, characteristically depressed at least one year developmentally, which include deficiencies of both speech and language. This speech and language behavior may occur concomitantly with conditions such as mental retardation, hearing loss, brain injuries, emotional disturbance or lack of experiential stimulation. (This category generally applies to those pupils whose chronological/mental ages are eight (8) years or below).[2]

3. Language/Learning Disability — a significant discrepancy (i.e., one standard deviation) between verbal and performance IQ scores and/or between auditory and verbal language scores. It should be determined that "this discrepancy is not primarily the result of (1) visual, hearing, or motor handicaps; (2) mental retardation; (3) emotional disturbance; or (4) environmental, cultural, or economic disadvantage."[2]

   (The "language/learning" disability may be characterized as an imperfect ability to listen, think, or speak, as opposed to an "academic" learning disability which primarily involves reading, spelling, writing, and the ability to do mathematical calculations. The speech/language clinician should be a member of the evaluation team in diagnosing specific language/learning disabilities and will generally be involved in the direct treatment of language/learning disabilities.)

b. Language Components[7]

1. *Morphology* — Perception or production of the fourteen (14) commonly accepted morphemes or affixes (Brown, 1974) in a manner in which the fully competent user of the native language uses them.

2. *Syntax* — Understanding and usage of phrases or sentences consistent with grammatical rules.

3. *Semantics* — Comprehension of words, grammatical forms or structures imposed by time (temporal ordering of logical production), meaning, or context underlying the logical grammatical structure of the native language.

4. *Language Processing* — The art of retrieving, perceiving, and interpreting spoken or written language within the structure of the native language.

5. *Other* — An example of another language component is pragmatics (Functional Use) which is the utilization of language appropriate to the social context of the given situation (i.e., cannot interact in the conversation, says the "wrong thing at the wrong time," etc.).

II. Assessment Considerations

A minimum battery of two (2) diagnostic measures is recommended. Each major language component (morphology, semantics, syntax, language processing) should be measured. These measures may include normed tests, criterion referenced tests, and/or a language sample. Scores should be computed in SD, LQ, percentiles and/or stanine scores, when possible.

When evaluating a pupil with a language problem, a comparison should be made between the pupil's language age scores (as determined by two (2) or more diagnostic measures) and the chronological age, mental age, and/or the overall language performance of the school population.

Language quotient (LQ) refers to any language component or components that are deficient. Pupils who are eligible for EMH, TMH, or PHM services should have their LQ determined by comparing language age (LA) to mental age (MA) utilizing a performance intelligence quotient (IQ) derived from standardized measures of intelligence. Formulas for computing LQ, MA, and IQ are provided below.

$$LQ = \frac{LA}{CA \text{ or } MA} \times 100 \qquad MA = \frac{IQ}{100} \times CA \qquad IQ = \frac{MA}{CA} \times 100$$

III. Criteria for Case Selection

Criteria for case selection for EMH, TMH, or PMH are addressed in separate sections (reference pages 23 and 24).

Rating	Classification	Characteristics
0	Normal Articulation	No language problems.
1	Developmental	Chronological/mental age usually eight (8) years or below. Language errors are generally inconsistent and mild. Appropriate diagnostic tests indicate a 1-12 month delay from normal language behavior.
2	Deviation (mild)	Conversational speech shows indications of a language deficit. Appropriate diagnostic tests indicate a language problem according to one (1) or more of the following measures: (a) 1 to 1½ SD below the mean (b) LQ of 80-85 (c) 11-22 percentile (d) Stanine 3.
3	Deviation (moderate)	Usually interferes with communication and educational progress. Frequently is accompanied by a phonological problem. Poor auditory comprehension and vocabulary skills which often affect the ability to follow directions and retain information presented auditorily. Appropriate diagnostic tests indicate a language problem according to one or more of the following measures: (a) 1½ to 2 SD below the mean (b) LQ of 70-79 (c) 3 to 10 percentile (d) Stanine 2.
4	Disorder (severe)	Interferes with communication and educational progress. Usually accompanied by a phonological problem. Can range from no useable language to limited content, and responses are frequently inappropriate to the topic at hand or to questions posed. Appropriate diagnostic tests indicate a language problem according to one or more of the following measures: (a) more than 2 SD below the mean (b) LQ at or below 69 (c) below 3 percentile (d) Stanine 1.
D	Dialectal Differences	Syntactical and morphological (linguistic) differences which are common to a particular cultural group including native speakers of a foreign language, speakers from a particular geographic region, and speakers of Black dialect. Speakers shall

exhibit three (3) or more of the linguistic features common to their dialect. Linguistic features of one of the more common dialects, Black dialect, are listed in Appendix C, page 27. The presence of a dialect alone (0D) does not usually result in interference of communication within the given speech community.

Students classified as "D" shall also be ranked according to the (0-4) Severity Rating Scale as follows:

0D Dialect speaker with no language problem.
1D Dialect speaker with a developmental language problem.
2D Dialect speaker with a mild language deviation.
3D Dialect speaker with a moderate language deviation.
4D Dialect speaker with a severe language disorder.

REFERENCE APPENDIX F FOR LISTING OF EVALUATION INSTRUMENTS FOR LANGUAGE

LANGUAGE WORKSHEET

I. Instructions for determining *Language Severity Rating*.

A. Compute the Language Severity Classification

1. Administer appropriate language tests to the student.
2. List the language tests/subtests and scores in Chart B below.
*3. Check (✓) on Chart B all appropriate language components measured by each test and indicate the deficit areas by placing a circle (o) around each check (✓) as appropriate.
4. Determine the severity for each test/subtest by referring to the information listed in Item C. Record severity classification (mild, moderate, severe) for each test you list in Chart B.
5. Determine and record the most frequently occurring Classification:
   a. If deficit appears in only *one* (1) component, the language severity classification is mild. (Disregard classification column on Chart B.)
   b. If deficit appears in *two* (2) or more components, the final severity is the most frequently occurring severity classification appearing in Chart B.

B. Diagnostic Chart CA _____ MA_____

			MAJOR LANGUAGE COMPONENTS				
Language Tests/Subtests	Derived Score	Language Severity Classification	Morphology	Syntax	Semantics	Language Processing	Other

*Reference Sample, Appendix E, page 29

C. Determine Language Severity Rating based upon diagnostic information in Chart B and indicate with a check (✓) below.

_____ Developmental — 1-12 month delay from normal language behavior in a child eight (8) years (CA/MA) of age or younger.

_____ Deviation (mild)
a. 1-1½ SD below the mean
b. LQ of 80-85
c. 11-22 percentile
d. Stanine 3

_____	Deviation (moderate)	a. 1½-2 SD below the mean b. LQ of 70-79 c. 3-10 percentile d. Stanine 2
_____	Disorder (severe)	a. below 2nd SD b. LQ below 69 c. below 3 percentile d. Stanine 1

II. Other factors to be considered (check (✓) as appropriate). These factors may be used to *raise* or *lower* the above severity by one level.

FACTORS	SELDOM (developmental)	OCCASIONALLY (deviation-mild)	FREQUENTLY (deviation-moderate)	ALMOST ALWAYS (disorder-severe)
A. Language skills are non-functional: 1. receptive 2. expressive				
B. Linguistic performance differs from the communicative intent and interferes with the intended message.				
C. Pragmatic behaviors observed: 1. Hesitations/revisions 2. Linguistic non-fluency 3. Poor attending skills 4. Delays before responding 5. Nonspecific vocabulary 6. Inappropriate responses 7. Poor topic maintenance 8. Need for repetition of instructions, questions, etc.				
D. Other (specify)				

III. Language Severity Rating (Check (✓) below):

_____ 0 — Normal Language	_____ D — Dialect
_____ 1 — Developmental	_____ D — Dialect
_____ 2 — Deviation (mild)	_____ D — Dialect
_____ 3 — Deviation (moderate)	_____ D — Dialect
_____ 4 — Disorder (severe)	_____ D — Dialect

EDUCABLY MENTALLY HANDICAPPED (EMH)
AND
TRAINABLE MENTALLY HANDICAPPED (TMH)

I. **Types of Services:**

A. Direct Intervention

1. "Traditional" speech/language therapy.
2. Speech Improvement/Language Development groups.
3. Communication training groups to emphasize functional communication skills in students' environments.
4. Alternative methods of communication training (e.g., total communication, communication boards, electronic communication devices, etc.).

B. Indirect Intervention

a. Teacher/parent consultation.

2. Team-teaching with classroom teacher.

II. **Eligibility Requirements**

Any EMH or TMH student whose standardized speech and language tests indicate a speech and language lag of one or more years below the mental age would be eligible for direct intervention (therapy), providing the mental age assessment has been obtained from psychological evaluation within a current three-year period. Whenever feasible the mental age should be derived from the performance scores (rather than language scores) from any standardized measure of intelligence. The formula for computing M.A. (mental age) is as follows:

$$MA = IQ \div 100 \times CA$$

A. If psychological testing needs updating or if a psychological evaluation cannot be administered (or is considered invalid), the following criteria, based on speech and language samples, may be used in determining eligibility for direct intervention:

1. Expected mental developmental norms.
2. Intelligibility rating.
3. Mean Length of Response (MLR).
4. Type and degree of error in language function.
5. Total verbal output.
6. Anecdotal reports and observations.

B. Direct speech/language therapy is generally contraindicated for EMH and TMH students whose speech and language proficiency is equivalent to their mental ages. However, if the scores on a standardized language test are commensurate with a student's M.A. but the criteria listed above are present, clinical judgment may indicate the necessity for direct intervention; a one-year trial placement in therapy is recommended.

C. When direct therapeutic services have been provided, the amount of progress made as well as the prognosis for improvement should be considered in determining the type and extent of services to be implemented the following year.

D. Higher functioning EMH children may be more appropriately prioritized according to criteria established in the Articulation and Language scales.

PROFOUNDLY MENTALLY HANDICAPPED (PMH)

The following program eligibility guidelines are recommended for PMH students:

I. **Level 1**

Communication/language functioning is between the 0-6 month level. Indirect intervention is recommended, when and if applicable.

II. **Level 2**

Communication/language functioning is between the 6-18 month level. Indirect intervention is recommended, when and if appropriate. In some cases, however, direct intervention may also be warranted, based upon the decision of the IEP team.

III. **Level 3**

Communication/language functioning is above the 18 month level. Both direct and indirect intervention are generally indicated. However, consideration should be given to the following factors before final recommendations for speech/language services are made.

(a) Chronological and mental age considerations.

(b) Physical abilities and medical considerations.

(c) Behavior.

(d) Motivation.

(e) Student's physical and social environments.

(f) Limitations of formal evaluations.

(g) Receptive-expressive language discrepancies.

(h) Student's current and future educational and vocational priorities and needs.

(i) Type and amount of professional and parental assistance available.

When direct therapeutic services have been provided, the amount of progress made as well as the prognosis for improvement should be considered in determining the type and extent of services to be implemented the following year.

APPENDIX A

*ELIGIBILITY FOR SPEECH/LANGUAGE SERVICES

STUDENT'S NAME _____

SCHOOL _____ GRADE _____

Area	Initial Severity Rating	Reevaluation Severity Rating
Articulation	_____	_____
Language	_____	_____
Fluency	_____	_____
Voice	_____	_____
Combined (Total Rating)	_____	_____

RECOMMENDED SPEECH/LANGUAGE SERVICES: (Check all appropriate)

_____ None

_____ Re-check in (month/year) _____

_____ Teacher/Parent Consultation

_____ Referral: Type _____

_____ Speech Improvement/Language Development (minutes/week _____)

_____ Group Therapy (minutes/week _____)

_____ Individual Therapy (minutes/week _____)

_____ Other _____

Date Recommendations Made _____

Date Recommendations Implemented _____

_____
Signature, Speech/Language Clinician

*Information addressed in the "Participation Form" contained in the *Procedures for Survey, Screening, Evaluation, Placement and Dismissal of Children Into/Out of Programs for the Handicapped* or in the pupil's IEP may be substituted for this form.

APPENDIX B

SOME PHONOLOGICAL FEATURES OF BLACK DIALECT

	FEATURE	EXAMPLE
1.	Omission of the final consonant in a two-item cluster when both members of the cluster are voiced or voiceless.	"Tes" for "Test"
2.	In formation of plurals, words ending in "s" plus "p," "t," and "k," add the "es" plural instead of the "s" plural.	"Tesses" for "Tests"
3.	d/ Initial substitution.	"Dis" for "This"
4.	t/ Initial substitution.	"Tought" for "Thought"
5.	fr/ Initial substitution.	"Free" for "Three"
6.	f/ Medial and final substitutions.	"Nuffin" for "Nothing" "Mouf" for "Mouth"
7.	v/ Medial and final substitutions	"Feaver" for "Feather" "Breave" for "Breathe"
8.	l (-) Contracted form.	"I" for "I'll"
9.	r (-) when followed by a consonant.	"Professuh" for "Professor"
10.	Devoicing of "b," "d," and "g" in final position of syllables.	p/b; t/d; k/g
11.	Omission of final "d"	"ba" for "bad"
12.	Nasalized vowel for nasalized consonant.	"ma . . ." (vowel prolongation) for "man"
13.	Overstressing of initial prefix "re" and final syllable "ment." Also overstressing some first rather than second syllables.	re'ceive re-tire-ment' po'-lice
14.	Skr/str	"skreet" for "street"
15.	Distortion for "ch" (all positions)	mild to moderate
16.	ks/sk	"aks" for "ask"
17.	sk/st (final position)	"wrisk" for "wrist"

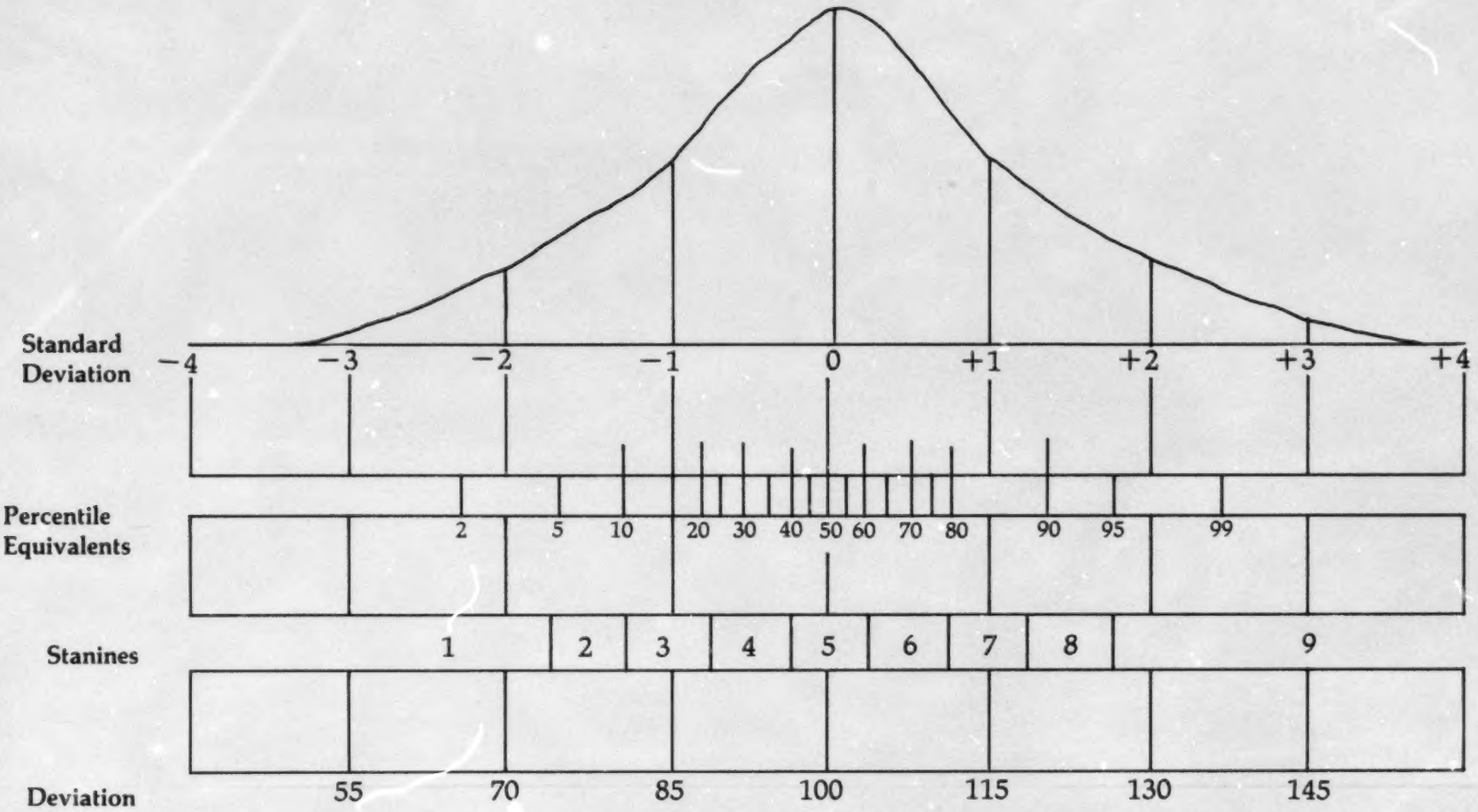
APPENDIX C

EXAMPLES OF NON-STANDARD LINGUISTIC FEATURES*

This Appendix includes only those typical morphological and syntactical structures which are the most stigmatized in the classroom. Many other non-standard grammatical features may be identified which are less conspicuous and which interfere minimally with communication. Other grammatical differences may be associated with regional dialects exhibited in specific geographical communities within the state. Yet other students may exhibit non-standard grammatical differences which are deviant rather than dialectal. Clinician knowledge of the language spoken in the community is essential in identifying dialectal linguistic patterns.

	Feature	Example
1.	Omission of past tense (-ed) form.	"He walk home yesterday."
2.	Use of present tense verb form for particular irregular verbs.	"He do that yesterday."
3.	Use of "be" or "been" to denote remote or continual time construction.	"He be playing every day." "He been had a dog for a year."
4.	Omission of the (-s) suffix to mark present tense with third person singular subjects.	"He walk home."
5.	Hypercorrection for first person present tense.	"I walks home every day."
6.	Absence of forms of "to be" (is, are).	"That dude bad." "They playing outside."
7.	Use of "ain't" for "didn't."	"I ain't know."
8.	Use of "'on't" for "don't."	"I 'on't know."
9.	Absence of ('s) suffixes in possessives.	"The boy hat."
10.	Use of "mines" for "mine" in possessives.	"This mines."
11.	Absence of (-s) or (-es) suffixes which mark plurals.	"He took two book."
12.	Use of (-s) suffix for pluralization or irregular nouns.	"Two foots," "two mans," etc.
13.	Inversion of word order in questions.	"Where the white cat is?" "What that is?"

*Fasold, R. W. and Wolfram W. "Some Features of Negro Dialect." Language Speech and Hearing Services in the Schools, 16-49 (1972).



*The Normal Curve and Standard Scores. New York: The Psychological Corporation.

APPENDIX E

B. Diagnostic Chart (Sample)

CA 6-7 MA 5-2
(full scale WISC-R)

Language Tests/Subtests	Derived Score	Language Severity Classification	MAJOR LANGUAGE COMPONENTS: Morphology	Syntax	Semantics	Language Processing	Other
PPVT (B)	<3%	severe			✓		
BOEHM	10%	moderate			✓		
TOLD ss	LQ 66	severe			✓		
pic. voc 2	2nd SD						
o. voc. 5	2nd SD				✓		
gram. und. 2	2nd SD			✓			
sent. imm. 4			✓	✓			
gram. comp. 3			✓	✓			
CELF							
word/sent. struc. (20)				✓			
word class (3)					✓		
Ling. conc. (28)					✓		
rel./amb. (3)	Processing			✓	✓	✓	
oral dir. (12)	5%	moderate			✓	✓	
spok. para (7)					✓	✓	
c. naming (0)						✓	
word asso. (14)	Production				✓	✓	
model sent. (10)	<5%	severe	✓	✓			
form. sent. (3)			✓	✓	✓		
Lang. Sample	6% mazing					✓	
	57% restricted						
	47% semantic restrictions				✓		
	63% syntactic restrictions		✓	✓			
ACLC							
2 crit. elem.	80%						
3 crit. elem.	70%						
4 crit. elem.	40%				✓	✓	

APPENDIX F

EVALUATION INSTRUMENTS FOR SPEECH AND LANGUAGE

I.	**Phonology** — speech sounds used by child*	Ohio Tests of Articulation and Perception of Sounds Goldman-Fristoe Test of Articulation Arizona Test of Articulation Proficiency Fisher-Logeman Test of Articulation Weiss Comprehensive Articulation Test MacDonald Deep Test of Articulation Photo Articulation Test Templin-Darley Test of Articulation Test of Language Development (Word Discrimination, Word Articulation)
II.	**Morphology** — includes such things as the child's use of tenses, plurals, possessives, comparatives, etc.*	Test of Auditory Comprehension of Language Northwestern Syntax Screening Test Carrow Elicited Language Inventory Illinois Test of Psycholinguistic Abilities (Grammatic Closure) Structured Photo Language Test Developmental Sentence Scoring Language Sample Analysis of spontaneous language samples Language Sampling and Analysis-Supplement to the Utah Test of Language Development
III.	**Syntax** — word order, phrase and sentence structure used by child*	Test of Auditory Comprehension of Language Northwestern Syntax Screening Test Carrow Elicited Language Inventory Structured Photo Language Test PCLT (Monterey Language Program) Assessment of Children's Language Comprehension Test of Language Development (Grammatic Understanding, Sentence Imitation, Grammatic Completion) Analysis of spontaneous language samples Language Sampling and Analysis-Supplement to the Utah Test of Language Development
IV.	**Semantics** — word meanings, vocabulary growth, understanding of concepts*	Peabody Picture Vocabulary Test Bangs Language Comprehension Basic Concept Inventory — Engleman Test of Language Development (Picture Vocabulary, Oral Vocabulary) Boehm Test of Basic Concepts Illinois Test of Psycholinguistic Abilities (Auditory Reception, Visual Association, Manual Expression, Verbal Expression subtests) Analysis of spontaneous language samples Kraner Preschool Math Vocabulary Comprehension Scale
V.	**Supplementary tests** — including developmental tests, cognitive skills and auditory skills*	Utah Test of Language Development Houston Test of Language Development Zimmerman Preschool Language Scale Columbia Mental Maturity Scale McCarthy Scale of Children's Abilities

		Peabody Picture Vocabulary Test Test of Language Development Illinois Test of Psycholinguistic Abilities Goldman-Fristoe-Woodcock Auditory Test Battery Wepman Auditory Discrimination Test Quick Neurological Screening Test Goldman-Fristoe-Woodcock Test of Auditory Discrimination Linda Mood Auditory Conceptualization Test Basic School Skills Inventory Illinois Children's Language Assessment Test Test of Nonverbal Discrimination Muma Assessment Program Myklebust Picture Story Language Test Michigan Picture Language Inventory Porch Index of Communicative Ability in Children Dailey Language Facility Test Structured Photographic Language Test
VI.	**Supplementary tests** — appropriate for older children*	Detroit Test of Learning Aptitude Test of Adolescent Language (TOAL) Dailey Language Facility Test Specific Language Disability Test
VII.	**Fluency****	The Stocker Probe Personalized Fluency Control Stuttering Interview (Ryan) Stuttering Severity Instrument (Riley) Precision Fluency Shaping (Webster) Monterey Fluency Interview
VIII.	**Voice*****	Voice Disorders (Wilson) Informal Rating Scale
IX.	**Screening Tests**	Informal (Clinician Made) Screening Picture Articulation and Language Screening Test Predictive Screening Test of Articulation First Grade Screening Test Kindergarten Language Screening Test Screening Test of Auditory Comprehension of Language Stephens Oral Language Screening Test Coston-Reidenbach Speech and Language Screening Fluharty Preschool Language Screening Test Northwestern Syntax Screening Test

*List developed by clinicians in Charleston County Schools.
**List compiled by clinicians representing the school district of Spartanburg County and the Greenville County Schools.
***List compiled by clinicians representing Lexington County School District #5 and Richland #1.

REFERENCES

1. Adopted from the *Iowa Severity Rating Scales for Communication Disabilities.*

2. Definitions provided for the areas of articulation (page 8), fluency (page 12), voice (page 15) and language (page 18) are State Board of Education regulations contained in the *Procedures for Survey, Screening, Evaluation, Placement and Dismissal of Children Into/Out of Programs for the Handicapped.*

3. *Greenville County Norms.* This developmental chart was used for a placement criteria field study conducted during the 1980-81 school term in the School District of Greenville County, Greenville, South Carolina. The chart was derived from developmental age norms utilized in the *Fisher-Logeman Test of Articulation* and the *Weiss Comprehensive Articulation Test.*

4. The definitions and the *Dysfluency Score* based on stuttered words per minute were derived from a fluency rating scale developed by the Charlotte-Mecklenburg School District, Charlotte, North Carolina.

5. The percentages utilized in computing the *Dysfluency Score* were derived from the *Precision Fluency Shaping Program,* Webster.

6. The *Vocal Characteristics Score* is based on a voice rating scale developed by the Charlotte-Mecklenburg School District, Charlotte, North Carolina.

7. Definitions were derived from information obtained from Pinellas County, Florida.